MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

443 02122

93d Reg. Dist. No. 351

EVIDENCE FOR ADDITION OF AGE & BIRTH DATE ISON: RLM No. 6119, 2-24-49.

1. PLACE OF DEATH: COUNTY Worcester MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newark	LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS No	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newark
	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Jennie	L	Ayers	2	7	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Female	a a	widow	Nov. 4, 1882	66 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Same	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Ayers	Jennie L. Massie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	No	John Ayers, Newark, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocarditis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c) Bronical Pneumonia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1948, to Feb 7, 1948, that I last saw the deceased alive on Feb 7, 1948, and that death occurred at 9 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Clifford E. Corbett	M.D.	Berlin Md.	

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2-11-49	Evergreen	Berlin	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/11/49	LeRoy Smith	James F. Stewart	402 E. Church St. Salisbury, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 16 1949
BUREAU V. S.

02123

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

770.0

CERTIFICATE OF DEATH

161c Reg. Dist. No. 351

1. PLACE OF DEATH: COUNTY Worcester Co MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cordletree Rural
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mary Beasley

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cordle tree
STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Mary Beasley

4. DATE OF DEATH (Month) (Day) (Year) February 15 1949

5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Feb 14, 1949
9. AGE last birthday [redacted] yrs. If under 1 year Months Days If under 24 hrs. Hours 23 Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Cordle tree, Worcester Co.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Bosie Beasley
14. MOTHER'S MAIDEN NAME Janie May Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Bosie Beasley, father

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Erythroblastosis Foetalis — INTERVAL BETWEEN ONSET AND DEATH 1 day

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/15/49, 19....., to 2/15/49, 19....., that I last saw the deceased alive on 2/15/49, 19....., and that death occurred at 6.30 P m., from the causes and on the date stated above.

SIGNATURE Paul Cohen (Degree or title) M.D. ADDRESS Snow Hill Md DATE SIGNED 2-16-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Feb 16/49
NAME OF CEMETERY OR CREMATORY Coulbourn
LOCATION (City, town, or county) Cordletree (State) Md

DATE REC'D BY LOCAL REG. 2/16/49
REGISTRAR'S SIGNATURE Leroy Smith
24. FUNERAL DIRECTOR Clay E. Timmis ADDRESS Snow Hill Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 443

02124

CERTIFICATE OF DEATH 93d Reg. Dist. No. 355

1. PLACE OF DEATH: COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newark; MARYLAND; LENGTH OF STAY (in this place) all life; HOSPITAL OR INSTITUTION OR STREET ADDRESS no	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Newark Md. COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newark; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print)	(First) Lizzie	(Middle)	(Last) Collins	4. DATE OF DEATH	(Month) 2	(Day) 28 (Year) 1949
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	a a	married	1880	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Same	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no; (If year, give war or dates of service) no	16. SOCIAL SECURITY NO. no	17. INFORMANT Mrs. Annie Timmons	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) MYOCARDITIS

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) HYPERTENSION

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1/1/40, 19....., to 2/28/49, 19....., that I last saw the deceased alive on 2/25/49, 19....., and that death occurred at 7 A M m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Alford E. Schott	M.D.	Berlin Md	

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	3-3-49	Cedar Chapel	Newark	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-2-49	Helen F. Hayward	James F. Stewart	402 E. Church St. Salisbury, Maryland

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

RECEIVED
MAR 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

421.4
92e

02125

Reg. Dist. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke (Rural) Unionville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural (Unionville)
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Conquest.

3.(b) Social Security Number

4. Sex: Male

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Cecil Brown Conquest

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): February 27 - 1898

8. AGE: Years: 51 Months: 0 Days: 1 If less than one day: hrs. min.

9. Birthplace: Temperanceville, Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: George Thomas Conquest
13. Birthplace: Accomack County Va

MOTHER
14. Maiden name: Mary Francis Douglas
15. Birthplace: Accomack County, Va

16. Informant: Cecil Conquest,
Address: Pocomoke, Md. (R.F.D.)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 2nd 1949 (month) (day) (year)

Cemetery or crematory: Wattsville

Location: Wattsville, Virginia.

18. Funeral director: J. Edgar Thomas
Address: Accomac Virginia

19. Feb. 28 1949 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28 1949 at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1948 to Feb 28 1949 and that I last saw him alive on Feb 27 1949

Immediate cause of death	DURATION
Endocarditis	6 days
Due to Influenza	3 day
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed: [illegible]

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

916.0

02126

CERTIFICATE OF DEATH

180 Reg. Dist. No. 355

1. PLACE OF DEATH
COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin, R.F.D. #2
LENGTH OF STAY (in this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Wo.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
STREET ADDRESS (If rural, give location) Berlin Md, R.F.D. #2

3. NAME OF DECEASED (Type or Print) (First) William (Middle) T. (Last) Dirickson

4. DATE OF DEATH (Month) Feb. (Day) 2 (Year) 1949

5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 4/14/1862 | 9. AGE last birthday 86 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown | 14. MOTHER'S MAIDEN NAME Martha Dirickson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. — | 17. INFORMANT Linnie Edna Purnell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Burned to death by fire — Interval between onset and death: ? ?

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Home Burned Down

19a. DATE OF OPERATION none | 19b. MAJOR FINDINGS OF OPERATION none | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | (CITY OR TOWN) nr Berlin Md, | (COUNTY) Wo. | (STATE) Md

TIME OF INJURY (Month) 2 (Day) 2 (Year) 49 (Hour) 11 55 a.m. | INJURY OCCURRED While at Work ☐ Not While At work ☒ | HOW DID INJURY Ooccur? Home Burned Down

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ on 2/3, 1949, ~~to~~, ~~19~~, that I last saw the deceased ~~alive~~ on 2/3, 1949, and that death occurred at 11 55 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
J. Swasche M.D Snow Hill Md 2/3/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Feb 8-49 | NAME OF CEMETERY OR CREMATORY Bishopsteen | LOCATION (City, town, or county) (State) Berlin Md

DATE REC'D BY LOCAL REG. 2-4-49 | REGISTRAR'S SIGNATURE Helen F Hayward | 24. FUNERAL DIRECTOR James R Stewart | ADDRESS Salisbury Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 442 02127

CERTIFICATE OF DEATH 1310 Reg. Dist. No. 351

WITHIN CITY LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Worcester; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill; LENGTH OF STAY (In this place) 15 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Mary	Elizabeth	Godfrey	Feb	23	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	Aug. 4 1871	77-6-2 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Snow Hill Md R.F.D.	U

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Theodore Blades	Ellen Dickerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	
no	None	Hugh B. Truitt	231 St Paul Place Balto 2 Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Vascular Accident	24 Hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive - Cardiovascular - - Renal - disease	10 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June 15, 1946, to Feb. 22, 1949, that I last saw the deceased alive on Feb. 22, 1949, and that death occurred at 1:25 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Robert L. LaMar	MD	Snow Hill Md.	2-24-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 25 49	Spring Hill	Buckingham,	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/24/49	LeRoy Lewis	Clay E. Timmons	Snow Hill Md

VS. A15

RECEIVED
FEB 28 1949
BUREAU V. S.

RECEIVED
FEB 28 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

443 93d 02128

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH
COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Worcester.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin.
STREET ADDRESS (If rural give location) N. Main St.

3. NAME OF DECEASED (Type or Print) (First) Lucinda (Middle) Ellen (Last) Holloway
4. DATE OF DEATH (Month) 2 (Day) 9 (Year) 1949
5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH 12/18/1857
9. AGE last birthday 91 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Wango Wic. Co Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Morris
14. MOTHER'S MAIDEN NAME Hannah Shockley.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. William Outten.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Edema	72 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	20 yrs
	(c) Hypertension	20 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE (Home, farm, factory, street, office bldg., etc.) Home
(CITY OR TOWN) Berlin (COUNTY) Worcester, (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) None m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to Feb, 1949, that I last saw the deceased alive on Feb 8, 1949, and that death occurred at 6:15 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
T. J. O'Donnell	M.D.	Berlin Md,	Feb. 11, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/11/49	Evergreen	Berlin	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-11-49	Helen F. Hayward	Emma A. Bunting	Berlin Md.

RECEIVED
FEB 14 1949
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

002 02129

CERTIFICATE OF DEATH

136 Reg. Dist. No. 350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Worcester — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pocomoke — LENGTH OF STAY (in this place): 45 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 624 Cedar Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland. — COUNTY: Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pocomoke City
STREET ADDRESS (If rural give location): 624 Cedar Street

3. NAME OF DECEASED (Type or Print): (First) ERNEST (Middle) S (Last) INGERSOLL

4. DATE OF DEATH: (Month) Feb (Day) 3 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 12-1882

9. AGE last birthday: 66 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Giddletree, Worcester Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Arron Ingersoll

14. MOTHER'S MAIDEN NAME: Emma Lilliel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: 213-01-8905

17. INFORMANT: Mrs Jennie D. Ingersoll.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchial Pneumonia	1 wk.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pulmonary Tuberculosis.	1 Year.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN) (COUNTY) (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1949 to Feb. 3, 1949 that I last saw the deceased alive on Feb. 3, 1949 and that death occurred at 4 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Louis L. Llewelyn, MD. — ADDRESS: Pocomoke City, Md — DATE SIGNED: 2/4/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Feb 6-1949 — NAME OF CEMETERY OR CREMATORY: Bethany M.P. Cemetery — LOCATION (City, town, or county) (State): Pocomoke, Worcester Md.

DATE REC'D BY LOCAL REGISTRAR: February 5, 1949 — REGISTRAR'S SIGNATURE: Anne E. White

24. FUNERAL DIRECTOR — ADDRESS: Henry H. Watson, Pocomoke Md.

RECEIVED
FEB 7 1949
BUREAU V. S.

2/13/3/111

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

153 462

02130

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH
COUNTY: Worcester — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Berlin (Rural) — LENGTH OF STAY (in this place): 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Berlin
STREET ADDRESS (If rural give location): R.F.D. St. Martins

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Margaret	Selby	Jacobs.	Feb	9	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	white	married	Mar. 3, 1861	87 yrs		6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife			

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William B. R. Selby	Rebecca Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Mrs. Robbins Jacobs Berlin Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma of Transverse Colon c intestinal obstruction	1 yr
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Marasmus & Inanition	2 weeks
	(c) Generalized atherosclerosis	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 10-1, 19 48, to 2-8, 19 49, that I last saw the deceased alive on 2-8, 19 49, and that death occurred at 3 45 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Hermann H. Robbins	M.d	Bay St. Berlin, Md	2-10-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/12/49	Jacobs Family Plot	Berlin R.F.D.	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-12-49	Helen F. Hayward.	Dana A. Bunting	Berlin Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
FEB 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02131

2411 N. Charles Street, Baltimore

442
52a

CERTIFICATE OF DEATH

Reg. Dist. No. 351

WITHIN BOARD OF HEALTH LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Worcester — STATE MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Elizabeth	Jarman	Feb.	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	white	widow	5/30/1875	73 yrs.	8	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Gough	Lethi Powell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Mr. William Jarman.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Pulmonary Edema	2 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardiovascular Renal disease	3 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Inanition

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
3-25-48	Adenocarcinoma Right Kidney (removed)	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from April 20, 1948, to Feb. 20, 1949, that I last saw the deceased alive on Feb. 19, 1949, and that death occurred at 5:40 A m., from the causes and on the date stated above.

SIGNATURE Robert L. LaMar (Degree or title) M.D. ADDRESS Snow Hill DATE SIGNED 2-21-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/22/49	Buckingham	Berlin Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/21/49	LeRoy Smith	Duna A. Burbage	Berlin Md

VS. A15

RECEIVED
FEB 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

443
131a

02132

Reg. Dist. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Whaleyville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: ✓

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland. County: Worcester

City or town: Whaleyville (If outside city or town limits, write RURAL and give nearest town)

Street No. ✓ (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME: Benjamin Edward Lewis

3. (b) Social Security Number: —

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widower

6.(b) Name of husband or wife: Sallie Lewis.

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.): Aug 31 1865

8. AGE: Years 83 | Months 6 | Days 22 | If less than one day ... hrs. ... min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business: Laborer.

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Sallie Lewis
15. Birthplace: Md.

16. Informant: Sewell Lewis

Address: Bishop. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 25, 1949 (month) (day) (year)

Cemetery or crematory:

Location: Whaleyville. Md.

18. Funeral director: M. Pasha Watson

Address: Selbyville. Del.

19. 2. 25 1949 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 22 1949, at 900 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1948 19 to date of death and that I last saw him alive on 2-22-49 19

Immediate cause of death: Myocarditis Chronic Chr. int. nephritis. Hypertension.

DURATION: 2 yrs?

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank R Lewis M.D. M. D. or other

Address: Willards Md. Date signed: 2-28-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 2 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

420.1 94a 02133

Reg. Dist. No. 350

1. PLACE OF DEATH · COUNTY Worcester MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke
LENGTH OF STAY (in this place) 30
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke
STREET ADDRESS (If rural give location) 122 Maple St.

3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) K (Last) MORSE

4. DATE OF DEATH (Month) February (Day) 8 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Sept 6, 1900
9. AGE last birthday 48 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, eveu if retired) Mason
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William A. Morse
14. MOTHER'S MAIDEN NAME Sophronia Fulharty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Beatrice Morse

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Sudden Heart attack

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary insufficiency

(c) Coronary disease

INTERVAL BETWEEN ONSET AND DEATH 2 hours

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Unloaded heavy cement day of death

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 8, 1949, to Feb 8th, 1949, that I last saw the deceased alive on Feb 8th, 1949, and that death occurred at 11 50 P. m., from the causes and on the date stated above.

SIGNATURE N. E. Gastonius (Degree or title) ADDRESS Pocomoke City Md DATE SIGNED 2/9/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF February 11, 1949
NAME OF CEMETERY OR CREMATORY Remson M.E. Cemetery
LOCATION (City, town, or county) Rural Pocomoke (State) Md.

DATE REC'D BY LOCAL REG. Feb. 11, 1949
REGISTRAR'S SIGNATURE Anne E. White
24. FUNERAL DIRECTOR Henry H. Watson ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

002 138 02134

Reg. Dist. No. 351

WITHIN CITY LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Worcester — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Snow Hill — LENGTH OF STAY (In this place): 36 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Snow Hill
STREET ADDRESS (If rural, give location): Gallins

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	William	Kendall	Powell	Feb.	13	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Single	Nov. 13 - 1910	38-3-0 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver	J. T. Wells & Son	Whaleyville Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William K. Powell	Della Hancock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		220-01-9357	Mrs Wm. K. Powell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis — Interval between onset and death: 3 Yrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 10-1-48, 19..... to 2-13-49, 19....., that I last saw the deceased alive on 2-13-49, 19....., and that death occurred at 3.45 P m., from the causes and on the date stated above.

SIGNATURE: Paul Owen (Degree or title) — ADDRESS: Snow Hill Md — DATE SIGNED: 2-14-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 15/49	Bates Methodist	Snowhill	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/16/49	LeRoy Smith	Elay E. Timmis	Snowhill Md

RECEIVED
FEB 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

903.0 02135

CERTIFICATE OF DEATH 186a

Reg. Dist. No. 3 S S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Worcester · MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland · COUNTY: Wor.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Berlin · LENGTH OF STAY (in this place): 4 mo.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Berlin
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Bay Street	STREET ADDRESS (If rural give location): Williams St.

3. NAME OF DECEASED (Type or Print) First	Middle	Last	4. DATE OF DEATH (Month)	(Day)	(Year)
Malilda	Hodges	Purnell	Feb.	1	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White		Sept. 29, 1849	99 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Hodges	Ann Harwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	—	Mrs William Pitts

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hypostatic Pneumonia sec to	5 days
Antecedent cause(s)	Chronic degeneration myocarditis &	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized atherosclerosis & senility	
	(c) Frac. Simple, left Femur, Intertrochanteric	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile Dementia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7 Nov 1948	Frac as in B.1	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
Accident	Home	Berlin,	Worcester Co.	Md

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☑	HOW DID INJURY OCCUR?
Nov.	5	1948	3 p.m.		accidently slipped in bed room

22. I hereby certify that I attended the deceased from 5 Nov, 19 48, to 1 Feb, 19 49, that I last saw the deceased alive on 1 Feb, 19 49, and that death occurred at 11 25 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Herman A Rabbitt	M.D.	Berlin, Md.	2 Feb 49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	2/4/49	St. Pauls Episc Cemetery	Berlin, Wor.	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-4-49	Helen F. Hayward	Anna A. Burbage	Berlin, Md.

VS. A15

RECEIVED
FEB 9 1949
BUREAU

02136

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

443

CERTIFICATE OF DEATH 93d

Reg. Dist. No. 355

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin; MARYLAND R.F.D.; LENGTH OF STAY (in this place) 20 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Worcester; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BERLIN; STREET ADDRESS (If rural give location) FRIENDSHIP ROAD.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MAE	VERONICA	RICHARDSON	Feb	6	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
FEMALE	WHITE	MARRIED	appx 1884	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		NEW YORK CITY, N.Y.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
PHILIP DWYER	– AHEARN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		CAPT. JONES RICHARDSON,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocarditis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 1-15, 1949, to 2-6, 1949, that I last saw the deceased alive on 1-15, 1949, and that death occurred at 10 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Clifford E. Lokett	M.D	Berlin Md	

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/8/49	EVERGREEN	BERLIN	MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-8-49	Helen F. Hayward	Amos A. Burbage	

RECEIVED
FEB 14 1949
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

251 02137

CERTIFICATE OF DEATH 872 Reg. Dist. No. 355

1. PLACE OF DEATH
COUNTY Worcester MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
LENGTH OF STAY (in this place) 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS no

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Worcester COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin
STREET ADDRESS (If rural give location) W. Lower St

3. NAME OF DECEASED (Type or Print) (First) Hirank (Middle) Dorris (Last) Sawyer
4. DATE OF DEATH (Month) Feb (Day) 9th (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	a a.	no	Dec 19, 1945	3 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY no
11. BIRTHPLACE (State or foreign country) U.S.a.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Parsons
14. MOTHER'S MAIDEN NAME Annie B. Sawyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No. no
17. INFORMANT Annie B. Sawyer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bronchio Pneumonia — 2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Disease (Diplegia Spastic) — 3 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 Feb, 1949, to 9th Feb, 1949, that I last saw the deceased alive on 9th Feb, 1949, and that death occurred at 6:30 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Hermann A. Rabkin M.D. Berlin Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Feb 12-1949
NAME OF CEMETERY OR CREMATORY Evergreen
LOCATION (City, town, or county) Berlin (State) Md

DATE REC'D BY LOCAL REG. 2-12-49
REGISTRAR'S SIGNATURE Helen F. Hayward
24. FUNERAL DIRECTOR James H. Stewart ADDRESS Berlin, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02138

153
46e

Reg. Dist. No. 353

1. PLACE OF DEATH:
County Worcester
City or town Selbyville, Del. Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Selbyville, Del. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Bertha B. Showell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	married

6.(b) Name of husband or wife Edward B. Showell
6.(c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) Feb. 5, 1897

8. AGE: Years	Months	Days	If less than one day
51	11	27	hrs. min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Isaac Jones
13. Birthplace
MOTHER 14. Maiden name Sally Jones
15. Birthplace
16. Informant Edward Showell
Address Selbyville, Del. R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-4-49 (month) (day) (year)
Cemetary or crematory Sarah Dukes
Location Bishop, Md.
18. Funeral director Henry H. Watson
Address Pocomoke City, Md.
19. Feb. 3 1949 Mrs. Roy Bergey Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1949 at 10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947 to Feb. 2 1949
and that I last saw her alive on Feb. 2 1949

Immediate cause of death	DURATION
Uremia	2 days
Due to Carcinoma of the Large Bowel	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. J. Hanna M. D. or other
Address Selbyville, Del. Date signed 2/3/49

VS A15 9-45-15N

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.2 02139

CERTIFICATE OF DEATH

Reg. Dist. No. 350

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Worcester — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke — LENGTH OF STAY (In this place) one year	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampton
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location) 44 Bank Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
THOMAS	A	SPADY	Feb	23	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	Sept 28-1878	70 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming		Virginia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Spady	Maggie Scherer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes	WWar #1	-	Mr Stanley Bayly

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Sudden Fatal Syncope	1 to 3 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) C Anemia C nephritis	D.K. Months
(c) C myocarditis	D.K.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Refusal to take medicines	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Jan 25, 1949, to Feb 23, 1949, that I last saw the deceased alive on Jan 31, 1949 and that death occurred at 10:10 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
N. E. Watsons MD		Pocomoke City Md	2/24/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/25/49	Spady-Mrs Jarvis	Capeville,	Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 25, 1949	Anne E. White	Henry A. Watson	Pocomoke, Md.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02140

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46b

CERTIFICATE OF DEATH

Reg. Dist. No. 357

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Worcester — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Snow Hill Rural #1
LENGTH OF STAY (in this place): 6 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Snow Hill Rural #1
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Lena (Middle) R. (Last) Wise

4. DATE OF DEATH: (Month) Feb. (Day) 13 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 14-1877

9. AGE last birthday: 71-1-25 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: On Home

11. BIRTHPLACE (State or foreign country): Accomac, Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Planter

14. MOTHER'S MAIDEN NAME: Lucy Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ella Thomas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Anasarca	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Exanition & Hemorrhages	3 weeks
	(c) Carcinoma of the Stomach	6 mos.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Hypertensive Cardiovascular Renal	5 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15, 1948, to Feb 13, 1949, that I last saw the deceased alive on Feb 12, 1949, and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE: Robert G. LaMar (Degree or title: M.D.) ADDRESS: Snow Hill Md. DATE SIGNED: Feb. 15, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Feb. 16/49 — NAME OF CEMETERY OR CREMATORY: Baptist — LOCATION (City, town, or county) (State): Nassawadox, Virginia

DATE REC'D BY LOCAL REG.: 2/15/49 — REGISTRAR'S SIGNATURE: LeRoy Smith

24. FUNERAL DIRECTOR: Elay E. Timmins — ADDRESS: Snow Hill Md

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FEB 18 1949
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